



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

SENTRY INSURANCE A MUTUAL COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-4236-01

MFDR Date Received

February 23, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: \$1,439.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "2nd MRI not authorized. 1st MRI done on 6/29/05 at Open Imaging"

Response Submitted by: Sentry Insurance, PO Box 29466, Phoenix, AZ 85038

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2005	Outpatient Diagnostic Imaging Services	\$1,439.23	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not

provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. This request for medical fee dispute resolution was received by the Division on February 23, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 9, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. By letter dated August 2, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – DALLAS)* that specified, in pertinent parts, an "Additional Reimbursement Amount Owed" of \$554.77 and an "alternative" "Additional Reimbursement Amount Owed" of \$703.76. The Division notes that the amount in dispute of \$1,439.23 specified above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W4 – NO ADDITIONAL REIMBURSEMENT IS ALLOWED AFTER RECONSIDERATION
 - 62 – PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/ AUTHORIZATION

Findings

1. The insurance carrier denied the disputed service with reason code 62 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/ AUTHORIZATION." Former 28 Texas Administrative Code §134.600(b), effective January 1, 2003, 27 *Texas Register* 12359; states that "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care..." However, review of §134.600(h) and (i) finds that the service in dispute is not among the services listed as requiring preauthorization. The insurance carrier failed to provide documentation to support that the service in dispute is a repeat diagnostic study. This denial reason is not supported. The disputed service will be reviewed per applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's amended position statement asserts that "the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
 - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and... encourages health care providers to continue to offer quality medical care to injured employees... Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement... The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."

- Review of the submitted medical bill and the submitted medical records finds no principal procedure code listed for the services in dispute.
- Review of the submitted documentation finds insufficient information necessary to calculate a reimbursement amount under the methodology proposed by the requestor.
- The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement of \$554.77 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the additional amount sought is a fair and reasonable rate of reimbursement for the services in dispute.

3. In the alternative, the requestor proposes that “it is justifiable to order additional reimbursement under the Hospital Facility Fee Guidelines – Outpatient because the Division’s new fee guidelines, while not in effect at the time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for this date of service is available for calculating the amount due.” Review of the submitted documentation finds that:

- In support of the alternative requested reimbursement methodology the requestor states that “The data necessary to calculate the Maximum Allowable Reimbursement for this year of service is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure of the fair and reasonable reimbursement amount.”
- The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
- The fee guidelines as adopted in 28 Texas Administrative Code §134.403 were not in effect during the time period when the disputed services were rendered.
- The Division disagrees that the fee guidelines as set forth in §134.403 are “presumptively fair and reasonable reimbursement under the law” for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers’ compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
- The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for the alternative additional amount of \$703.76 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested would provide a fair and reasonable rate of reimbursement for the services in dispute.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

_____	Grayson Richardson	August 15, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.